Committee on Ways and Means

Summary of Medicare Modernization and Prescription Drug Act

Voluntary Rx Drug Benefit Available to ALL Medicare Beneficiaries

- All Medicare beneficiaries covered
- Those who want to stay with their current coverage, may do so, and employers encouraged to continue retiree coverage by receiving funding assistance.

Standard Benefit:

- $250 deductible
- $251- $2,000: 80% coverage, 20% cost-sharing
- Catastrophic protection after $3,700 out-of-pocket (100% of costs covered)
- Affordable premium around $35 per month or about $1 a day
- Front end benefit aids most seniors

Extra Assistance for Low-income

- Fully subsidized premium and cost-sharing up to 135% of poverty
- Premium subsidy phased out between 135% and 150%
- Medicare is primary payor
- State governments receive assistance by phasing out their Medicaid obligations over a number of years
- Allow tier cost-sharing up to $5

Beneficiaries Choose Plan that is Best for Them

- Choice of at least 2 plans guaranteed
    - Can choose actuarially equivalent benefit package
    - Can choose plan that has formulary (list of preferred drugs) and pharmacy network that best suits their needs
- Competition holds down costs

Quality Improvements to Improve Seniors Health

- Protections against adverse drug interactions
- Electronic prescribing to minimize medical errors
- Pharmacy therapy and chronic care management for chronic conditions
- Choice of any pharmacy

Long Overdue Modernizations

- Covers an initial physical and once every two year cholesterol screening
- Bipartisan regulatory relief and contractor reform
- Stabilization of Medicare+Choice followed by competitive bidding
- Rural relief package for underpaid rural hospitals and home health
- Competitive bidding for Durable Medical Equipment
- Reform of AWP drug pricing

Medicare Modernization

Medicare Advantage

Stabilization: 2004 and 2005

- Medicare+Choice would be renamed Medicare Advantage.
- Beginning in 2004, a payment option equal to the fee-for-service (FFS) rate (adjusted to include expenditures in VA or DoD facilities for services received by Medicare beneficiaries and indirect medical education costs) would be added.
- Medicare Advantage rate increases would equal *the greater of* the growth in Medicare per capita costs or 2 percent.
- All Medicare Advantage plans would be required to offer disease management one year after date of enactment.

Competition in 2006

- Plans would bid against a benchmark, equal to the Medicare Advantage rate.
- If the plan bid is less than the benchmark, the beneficiary would get 75% of the savings, and the government would retain 25%. If the plan bid is greater than the benchmark, the beneficiary would pay the excess to the plan. The government would pay the plan the benchmark amount.
- The Congressional Budget Office assumes that plans will bid their costs. Competitive bidding reduces costs because the government savings, generated when bids are below benchmarks, exceed increased costs from higher benchmarks.
- Beneficiaries in traditional Medicare would be unaffected.

Enhanced Fee-for-Service Option

- The country would be divided into at least 10 regions in 2006.
- Private enhanced fee-for-service (EFFS) plans (preferred provide organizations (PPOs) or FFS plans) would bid to offer the standard Medicare benefit package, and must offer coverage to all beneficiaries in the entire region.
- Plans would bid against a benchmark equal to the *average* of the Medicare Advantage rates in the region.

- Beneficiaries choosing EFFS plans with bids below the benchmark would share in the "savings" with the government, with beneficiaries getting 75% of the savings and the government getting 25%. Beneficiaries choosing EFFS plans with bids above the benchmark would pay the excess.

- All EFFS plans would be required to offer disease management, a single deductible and limit on out-of-pocket expenses. Enrollees would be prohibited from purchasing a Medigap policy to cover the deductible or half of the cost-sharing above the deductible.

- All EFFS plans would be required to charge a uniform premium and cost-sharing throughout the region.

FEHBP-Style Medicare Reform in 2010

- In 2010, FEHBP-style competition would begin nationwide in competitive areas.

- Competitive areas would offer Medicare beneficiaries access to two private plans – either two Medicare Advantage or two EFFS plans -- along with traditional FFS Medicare.

- In competitive areas:

    - Plans, including traditional FFS, would submit bids for covering standard Medicare benefits.

        - The benchmark would be set at the weighted average of all plan bids in the competitive area. The weight for traditional FFS Medicare would equal the nationwide proportion of Medicare beneficiaries enrolled in traditional FFS Medicare, or the regional proportion if higher. The weights for all other plans would equal the national proportion of beneficiaries enrolled in private plans, or the regional proportion if lower.

    - Beneficiaries enrolling in plans with bids below the benchmark would share the "savings" with the government, while beneficiaries enrolling in plans with bids above the benchmark would pay the excess.

- In non-competitive areas, without either two Medicare Advantage or two EFFS plans, the traditional FFS beneficiary premium would be unaffected.

Chronic Care Management Proposal

Individuals with multiple chronic conditions are more likely to be hospitalized, have more physician and home health visits, and fill more prescriptions for drugs.

Because Medicare is simply a payer of bills when seniors get sick, the program does not help beneficiaries manage their chronic diseases to stay well or to reduce program costs.

- 84% of Medicare beneficiaries have one or more chronic conditions
- 62% have two or more conditions.
- Individuals with chronic conditions account for 78% of all health care spending
- Two-thirds of Medicare spending is for people with five or more chronic conditions.

In order to improve health outcomes and reduce health costs, the bill provides chronic care management (CCM) for Medicare beneficiaries in the traditional fee-for-service program, as well as in Medicare Advantage and Enhanced fee-for-service (EFFS).

These CCM programs would be budget neutral and provide the following services:

- A single point of contact to coordinate care across settings and providers.
- Self-management education for the beneficiary and support education for health care providers, primary caregivers, and family members.
- Coordination between health services and prescription drug benefits.
- Education about and assistance obtaining hospice, pain management, palliative, and end of life care.
- Participation is voluntary.

Fee-for-Service CCM:

The Secretary would contract with management companies through a regional competitive bidding process to provide chronic care management. Multiple winners would be selected in each region in the United States.

Contractors must:

- Be accredited by qualified organizations.
- Identify and enroll eligible beneficiaries through claims data.
- Accept risk-sharing as part of the contract.

The Secretary would make initial contact with the beneficiary and would provide information concerning CCM programs offered in the beneficiaries' region.

Medicare Advantage and Enhanced Fee-for-Service CCM:

- The provision of chronic care management programs would be a requirement for private plans.

- Most Medicare HMOs currently provide chronic care management programs.

Indexing the Medicare Part B Deductible

- Medicare is the nation's health insurance program for Americans age 65 and older and certain disabled individuals. Medicare consists of two distinct parts -- Part A (Hospital Insurance (HI)) and Part B (Supplementary Medical Insurance (SMI)). In general, Part A covers inpatient hospitalizations, skilled nursing care, and home health services. Part B covers physician services and care received in hospital outpatient facilities.

- Medicare includes two deductibles – $840 for an inpatient hospitalization under Part A Medicare, and $100 for services under Part B. In most cases, a beneficiary must pay the deductible before Medicare covers any costs of medical care or services.

- Most private insurance plans for the under-65 population include a single deductible which applies to most services, often excluding preventive care.

- Medicare's larger Part A deductible applies to hospitalizations for inpatient procedures, when a beneficiary is less likely to be sensitive to pricing issues. In contrast, when a beneficiary receives outpatient care, and is arguably more sensitive to costs, the beneficiary must pay the separate, smaller $100 Part B deductible.

- In 1966, Medicare's $50 Part B deductible equaled about 45 percent Part B charges. Today's $100 deductible equals about 3 percent of such charges.

- Indexing the Part B deductible to grow at the same rate as total Part B spending per beneficiary would maintain the deductible at 3 percent of such charges over time.

- An unchanged Part B deductible is a benefit increase over time, as costs of medical care rise. Beneficiaries pay about 25 percent of this benefit increase, through increased Part B premiums; taxpayers finance the remaining 75 percent.

- The deductible would rise from $100 in 2003 to $104 in 2004, and grow with Medicare inflation thereafter.

- This change would save $100 million in 2004, and $8.3 billion over 10 years, according to CBO.

- About one-half of beneficiaries are insulated from Part B deductible increases, through Medigap, Medicaid, and employer-sponsored supplemental insurance which covers the Part B deductible.

- The Part B deductible has increased only three times since the beginning of Medicare, when it was $50: to $60 in 1973, $75 in 1982, and $100 in 1991.

Addressing Pharmacy Concerns in the Medicare Modernization Bill

Pharmacies are concerned about beneficiary access to pharmacies, pricing transparency issues and insurance risk. The bill would address their concerns in a number of ways, and is a significant improvement over last year's bill.

ACCESS

- **Any Willing Provider.** Last year's bill did not require a closed network, but did not require any willing provider either, so it was assumed that most plans would have restricted networks of pharmacies.
    - This year's bill would require plans to accept any and all pharmacies willing to agree to the terms and conditions of the plan, and permits those plans to offer discounts to beneficiaries if beneficiaries use pharmacies in their preferred networks.
- **Convenient access to pharmacies.** Last year's bill included a provision which required convenient access to pharmacies, as defined by the Secretary – not the plan.
    - This year's bill goes a step further by adopting the current Department of Defense TRICARE Standard for Prescription Drug Plans to ensure convenient access to pharmacies.
        - Urban: a pharmacy within two miles of 90% of the beneficiaries;
        - Suburban: a pharmacy within five miles of 90% of the beneficiaries;
        - Rural: a pharmacy within 15 miles of 70% of the beneficiaries.
    - Even with any willing pharmacy, it is necessary to include access requirements to ensure adequate networks for beneficiaries.
- **Long-term prescriptions at retail rather than mail order.** The bill would require plans to permit beneficiaries to fill their prescription at a community pharmacy rather than mail order. Beneficiaries would pay any differential between mail order and retail.
    - As in last year's bill, mail order only would be prohibited. Seniors must have access to a bricks and mortar pharmacy.

PRICING TRANSPARENCY

- **Transparency.** Pharmacies have asserted that PBMs are not passing rebates and discounts to seniors and pharmacies. In addition, recent articles in the Wall Street Journal suggest there may be illegal or inappropriate kickbacks from drug manufacturers to PBMs.
- The bill would require all discounts and rebate arrangements to be disclosed to the Secretary. Propriety information would be confidential. This disclosure concept is consistent with the structure of manufacturer price disclosures in the Medicaid law.

INSURANCE RISK

- **Pushing risk down to pharmacies.** Some pharmacies argue that under the bill PBMs would push insurance risk down to pharmacies. The bill would prevent this by clarifying that pharmacies could not accept insurance risk.

THE PHYSICAN ADVANTAGE MODEL

The Balanced Budget Act of 1997 specified that Medicare reimbursement for covered outpatient prescription drugs would equal 95 percent of the average wholesale price (AWP) for the drug. AWP is not defined by law or regulation. AWPs are reported by drug manufacturers to organizations that publish the data in compendia, which are used by Medicare carriers in calculating payment for Medicare covered drugs.

AWPs do not reflect the actual price paid by purchasers. The AWP for a product is often far greater than the acquisition cost paid by suppliers and physicians, due to a variety of rebates and other discounts made available to physicians by manufacturers. The HHS Inspector General and the General Accounting Office estimate annual overpayments top $1 billion in an $8.5 billion market. As a result of abuses in the current system, beneficiaries are paying hundreds of millions of dollars in inflated co-payments every year.

Physicians assert that the overpayment for drugs covers underpayment for practice expenses associated with providing care in outpatient settings. Due to a variety of outdated surveys and data adjustments by the Centers for Medicare and Medicaid Services (CMS), there is a need to adjust reimbursement for physicians, particularly oncologists.

Proposal

To correct the dual problems – the underpayment for physician practice expenses and the overpayment for drugs – the Ways & Means and Energy & Commerce Committees have developed a compromise proposal. This proposal, the "Physician Advantage" model, would fundamentally correct these two problems.

Practice Expense

To adjust physician practice expenses, the proposal would:

- Require CMS to use new survey data on practice expenses submitted by physician groups.

- Waive budget neutrality requirements so that increased practice expenses for chemotherapy administration and infusions, based on the new survey data, would not be financed by decreases in practice expenses for other services performed by other specialties.

Drug Reimbursement

The "Physician Advantage" model relies on a new, innovative model to ensure physicians will access to the therapies required for their patients. Under this new model,

all prescriptions would be based solely on clinical decisions, allowing doctors to be doctors.

Under this model, physicians would write a prescription; this script would be filled by a Medicare-contracted entity that would then dispense the product to the doctor on a timely basis. As a part of this program, Medicare will ensure that there are at least two contractors available in any individual region. Physicians, not Medicare, would elect the entity to serve as their contractor to supply the drugs needed in their practices.

The contractors would be responsible to supply all covered drugs for a geographic area for a period of time. Bids would provide prices for covered drugs and specify quality measures and ability to ship product.

The Medicare contracted entity, not the doctor, would be reimbursed by Medicare. Reimbursement would be determined by a competitive bidding process.

The Medicare contracted entity would be responsible for collection of the 20% co-insurance on the drug payment.

Quality Controls

The Secretary would set standards for service, shipment and delivery, and establish a grievance process to resolve disputes). New standards to prevent counterfeiting or adulteration of drugs would also be included .

Direct shipment of drugs to beneficiaries (so-called "Brown Bagging") would be prohibited. Physicians would be able to maintain an inventory under special rules developed by CMS in order to allow redosing of products to fit the needs of patients.

For physicians, there are several advantages to this model:

- Payment would be appropriate to compensate physician office expenses.
- Physicians would have a choice of multiple entities from which to choose. CMS would select multiple contractors through a competitively bid request for proposal to supply Medicare covered drugs.
- Physicians would have significantly lower costs for inventory and carrying interest.
- Physicians would not be required to collect the 20% Medicare co-pay for the drug portion of the service. This reduces bad debt costs for physician practices.

Implementation

CMS would phase in the program so that all drugs would be covered in the new model by 2006.